Print Form

New Jersey Sports Medicine and Performance Center LLC
689 Valley Road, Suite 104, Gillette, NJ 07933

Today's Date: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Date of Injury or Onset of Symptoms: _____

Briefly Describe Present Symptoms: ☐ RIGHT ☐ LEFT _____

_____

_____

What makes your pain better? _____

What makes your pain worse? _____

Have you had similar symptoms before? ☐ Yes ☐ No When? _____

List X-ray, MRI, or studies that have been done (DATE and LOCATION):

_____

List Physicians that have treated you for these symptoms:

_____

Did a health care provider recommend that you see us (NAME and ADDRESS)?

_____

Does this involve: ☐ Motor Vehicle Accident ☐ Liability ☐ Workman's Compensation

Medications/Vitamins/Supplements: ☐ NONE

_____

Allergies to any medications, latex, injections etc: ☐ NONE

_____

Past Medical History: ☐ NONE

_____

Previous Surgeries: ☐ NONE

_____

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Social History:

Smoking	☐ Occasional	☐ Moderate	☐ Heavy	☐ None	Quit ____ years ago
Alcohol	☐ Occasional	☐ Moderate	☐ Heavy	☐ None	
Substance Use	☐ Occasional	☐ Moderate	☐ Heavy	☐ None	
Exercise	☐ Occasional	☐ Moderate	☐ Heavy	☐ None	
Sleep	☐ Restful	☐ Non-restful	☐ Poor		

Occupation: _____

Family History:

☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Osteoporosis

Other: _____

Review of Systems (Are you currently experiencing any of the following):

General Health
- ☐ fatigue
- ☐ fever, sweats, chills
- ☐ recent weight change

Lungs (Respiratory)
- ☐ short of breath
- ☐ cough
- ☐ wheeze

Heart/Vascular
- ☐ chest pain
- ☐ irregular heart beat
- ☐ leg swelling
- ☐ leg cramping

Ear/nose/throat
- ☐ frequent infections
- ☐ allergy/hay fever
- ☐ sinus problems

Psychiatric
- ☐ feeling anxious
- ☐ feeling depressed
- ☐ suicidal
- ☐ counseling

Brain/Nerves
- ☐ headache
- ☐ dizziness
- ☐ blackouts
- ☐ numbness/tingling
- ☐ tremor/shaking
- ☐ weakness
- ☐ memory loss

Vision
- ☐ change in vision
- ☐ visual disturbances

Skin/Dermatology
- ☐ rash
- ☐ sores/wounds
- ☐ itching

Urinary/genital
- ☐ frequent urination
- ☐ nighttime urination
- ☐ blood in urine
- ☐ painful urination
- ☐ leaking urine
- ☐ discharge

Blood/Lymphatic
- ☐ anemia
- ☐ swollen lymph node
- ☐ bleeding/bruising

Endocrine/Metabolic
- ☐ elevated blood sugar
- ☐ excessive thirst
- ☐ excessive urination
- ☐ heat/cold intolerance
- ☐ hair loss/skin changes

Gastrointestinal
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habit
- ☐ abdominal pain
- ☐ abdominal bloating
- ☐ bloody/black stools
- ☐ nausea/vomiting

Bone/Joint/muscle
- ☐ joint swelling
- ☐ joint warmth
- ☐ joint stiffness
- ☐ muscle pain
- ☐ back pain
- ☐ arm pain
- ☐ leg pain
- ☐ weakness

Other problems:
_____
_____
_____

FEMALES:

Pregnant: ☐ Yes ☐ No Planning: ☐ Yes ☐ No
Menstrual Flow: ☐ Regular every month ☐ Irregular Days of flow_____ Length of cycle_____
Date of last menstrual period_____
Date of last pap_____ ☐ Normal ☐ Abnormal
Date of last mammogram_____ ☐ Normal ☐ Abnormal
Do you want to lose weight? ☐ Yes ☐ No Are you on a diet? ☐ Yes ☐ No
History of eating disorders? ☐ Yes ☐ No